Communicable Disease UPDATE

Newsletter of the Bureau of Communicable Disease Control, Massachusetts Department of Public Health Vol. 16, No.3 Summer 2008

Vaccinate Women—Ask the Experts

The following questions and answers were extracted from the June 2008 edition of the Immunization Action Coalition's ***Vaccinate Women*** publication. A complete version of these questions and answers and publication, can be accessed at: http://www.immunize.org/vw/vw0608.pdf.

Which vaccines are recommended to be given post-partum to mothers of newborns before hospital discharge?

The following vaccines are recommended for new mothers before they leave the hospital: (1) women who have not previously been vaccinated with Tdap need 1 dose to protect their newborn; (2) women who did not receive influenza vaccination during pregnancy need to be vaccinated if it is still influenza vaccination season (through May); (3) women who tested susceptible to rubella on prenatal testing need MMR vaccine; (4) women who are not immune to chickenpox need 2 doses of varicella vaccine, dose #1 before hospital discharge and dose #2 given 4–8 weeks after dose #1.

Sometimes I have to give 3 vaccines like Tdap, HepA, and HepB at the same visit. Can I put them in the same syringe?

No! Individual vaccines for adults should never be mixed in the same syringe.

After an adult has either been infected with or exposed to pertussis, is vaccination with Tdap recommended, and if so when?

Yes. Adults who have a history of pertussis disease generally should receive Tdap according to the routine recommendation. In the U.S., two Tdap products are licensed for use. Adacel® (sanofi pasteur) is licensed for use in persons age 11–64 years, and Boostrix® (GlaxoSmithKline), is licensed for persons age 10–18 years. This practice is recommended because the duration of protection induced by pertussis disease is unknown (waning might begin as early as 7 years after infection) and because diagnosis of pertussis can be difficult to confirm, particularly with tests other than culture for *Bordetella pertussis.* Administering pertussis vaccine to persons with a history of pertussis presents no theoretical risk. For details, visit CDC's published recommendations on this topic at http://www.cdc.gov/mmwr/PDF/rr/rr5517.pdf (pages 24–25).

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STD Prevention Website Launched for Young Adults in Massachusetts: www.STD411.org

Can a guy prevent a sexually-transmitted disease (STD) by peeing after sex? How do I talk to my boyfriend about using a condom? Where can I get tested for STD's and HIV in Massachusetts and what can I expect when I get there? These and many other questions are answered on a new website, www.STD411.org, which was launched in July, 2008. With the goal of reaching sexually-active people in their twenties, the website is designed to be user-friendly and easy to navigate while providing practical information to help people make healthy decisions to prevent STDs.

In 2007, Massachusetts residents aged 20-24 years had the highest incidence of gonorrhea (178 per 100,000) and chlamydia (1,310 per 100,000) among all age groups. The distribution of gonorrhea and chlamydia is widespread throughout Massachusetts, with a concentration in urban areas. STDs disproportionately impact communities of color living in metropolitan areas of Boston, Springfield, Worcester, Lowell, Lawrence, Fall River, Brockton, and New Bedford.

Through a partnership between MDPH and the AIDS Action Committee, the website is designed to be responsive to the recommendations made by young adults at focus groups conducted in Boston and Worcester. Common themes that emerged from the focus groups included the use of a diversity of people pictured on the site, a variety of emotions of the people in the photos, statistics that indicate how probable it is to get an STD, and where to get screening – including an STD clinic finder map. By surveying medical providers at STD clinics, "The Top 10 STD Questions" for men and women are posted on the site.

Plans are underway to market the www.STD411.org in the summer and fall 2008 through transit advertising, *The Phoenix*, *The Metro* and on popular websites for young adults.

AIDS Action has posters and palm cards for providers to display and distribute. Please contact Ashley Smith, hotlines coordinator at AIDS

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Look Inside!

Epidemiology

PLEASE HELP!

Communicable Disease Update Survey

We request your feedback so we can make the Communicable Disease Update more useful for you. Please take a few minutes to visit the following link and complete the survey. Thank you for your participation!

http://www.surveymonkey.com/s.aspx?sm=WKZEXIo3qM6xWSdRqr4Y9Q_3d_3d

"Flu: What You Can Do – Caring for People at Home" Fall 2008 Initiative

The Massachusetts Department of Public Health (MDPH), in collaboration with the Local Public Health Institute of Massachusetts, is pleased to announce the continuation of the statewide educational campaign ***Flu: What You Can Do – Caring for People at Home***. Phase I of this initiative was launched in November 2007 with the goal of providing the general public with information and tools to care for persons with influenza at home, including people with pandemic flu. MDPH continues to prioritize educating residents, with an overall goal to build citizen preparedness and community resiliency that will become very important during a pandemic.

MDPH would like to thank local public health professionals and other community partners whose involvement has been instrumental in the success of the campaign to date. The components of the initial phase last year included statewide distribution of educational materials and implementation of community outreach and education. Accomplishments over the past year include the distribution of 330,000 English, Spanish and Portuguese booklets; the distribution of a 22-minute video to all local boards of health and approximately 82 cable access stations; and the implementation of 23 "Educating Communities on Flu Care at Home" training sessions across the state that resulted in the preparation of 275 participants who help distribute materials and/or facilitate educational presentations within their communities or with their constituents.

As we move into the next flu season, our goal is to expand the campaign to reach even more members of the general public, including greater numbers of persons who do not speak English as their first language and those who may need special assistance during an emergency. MDPH is currently translating the booklet into Chinese, Vietnamese and Haitian Creole, developing lower literacy level educational materials and increasing partnerships with community members that represent diverse populations.

MDPH and the Local Public Health Institute will again be hosting a series of training sessions this fall to enable our regional and community partners to implement the campaign with constituents and volunteers at the local level. The training sessions will be similar to the ones held last season but will include more clinical information about flu care, based on feedback from last season's participants. If you haven't already, we hope that you can attend one of these sessions. Visit the Local Public Health Institute's website at www.masslocalinstitute.org for a calendar of sessions and to register. On the Institute website, you can also learn about the strategies that local public health professionals and others across the state have used to educate their communities during the campaign's first phase.

The MDPH website at: http://www.mass.gov/dph/flu contains all campaign materials, information on how to order materials and resources that can be utilized to reach members of your community.

Vaccinate Women

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Can a booster dose of Tdap be given to persons age 65 years and older?
No brand of Tdap is approved by FDA for persons age 65 years and older. ACIP does not recommend off-label use of Tdap for this age group. However, a clinician may choose to administer Tdap to a person age 65 years or older if both patient and clinician agree that the benefit of Tdap outweighs the risk of a local adverse event.

What are the CDC-recommended dosing intervals when using human papillomavirus (HPV) vaccine?
CDC recommends dose #2 be given 2 months after dose #1, and dose #3 be given 6 months after dose #1. The minimum interval between doses #1 and #2 is 4 weeks, and the minimum interval between doses #2 and #3 is 12 weeks. Overall, there must be an interval of at least 24 weeks between doses #1 and #3.

A patient received a dose of HPV vaccine before she knew she was pregnant. What should I tell her?
HPV vaccine has not been causally associated with adverse outcomes of pregnancy or adverse events in the developing fetus. However, data on vaccination during pregnancy are limited. If a woman is found to be pregnant after initiating the vaccination series, delay completion of the series until after the pregnancy. If a dose is administered during pregnancy, there is no indication for intervention. Merck, the vaccine's manufacturer, has established a registry of women who were vaccinated with HPV during pregnancy. You or your pregnant patient should report an exposure to HPV vaccine; call (800) 986-8999. More information on HPV vaccination during pregnancy is available in the package insert at:
www.merck.com/product/usa/pi_circulars/g/gardasil/gardasil_pi.pdf.

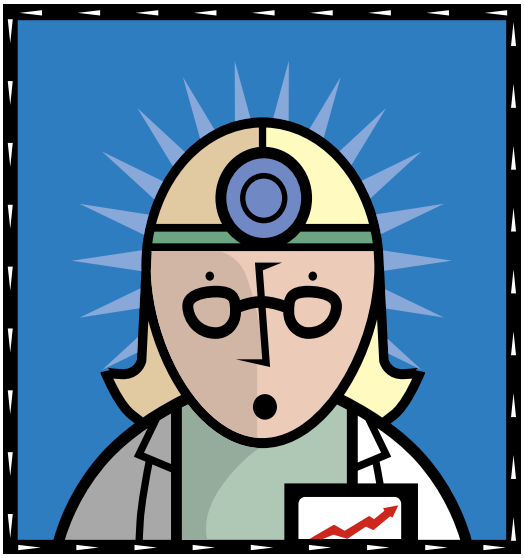
Can a woman who is breastfeeding receive HPV vaccine?
Yes.

Can HPV vaccine be administered at the same time as other vaccines?
Yes, it can.

Are pap smears still necessary for women who receive HPV vaccine?
Yes. Vaccinated women still need to see their healthcare provider for periodic cervical cancer screening. The vaccine does NOT provide protection against all types of HPV that cause cervical cancer, so even vaccinated women will still be at risk for some cancers from HPV.

Is the history of an abnormal pap a contraindication to the HPV vaccine series?
No. Even a woman found to be infected with a strain of HPV that is present in the vaccine could receive protection from the other 3 strains in the vaccine.

If a dose of HPV vaccine is significantly delayed, do I need to start the series over?
No, do not restart the series. Just pick up where the patient left off and complete the series.



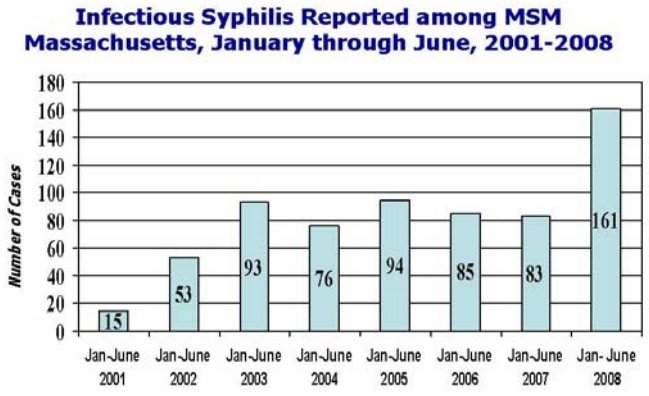
Immunization Program Milestones

During April and May, twelve Immunization Update conferences were held throughout the state. With nearly 1,400 participants, these conferences drew the largest audience since the Immunization Updates were introduced in 1999. A significant topic covered at the Immunization Updates was the transition to the Vaccine Management Business Improvement Project (VMBIP) or centralized vaccine distribution.

On June 23rd, Massachusetts had a very successful transition to VMBIP. With the advent of VMBIP, providers receive shipments of state-supplied vaccine directly at their office—they no longer have to go to a local board of health or local distributor to pick up vaccine. If you have any questions about centralized vaccine distribution, please contact the Vaccine Management Unit at 617-983-6828.

Rise in Infectious Syphilis Cases in 2008 Prompts Enhanced Public Education Directed tor Men Who Have Sex with Men (MSM)

After level incidence from 2003 through 2007, there has been a dramatic rise in infectious syphilis among MSM during the first six months of 2008. There were 161 cases of infectious syphilis in MSM reported from January through June, 2008, representing a 94% increase over the same period in 2007.



Addressing infectious syphilis includes engagement of the MSM community — a population that has been exposed to social marketing and safer sex messages for more than twenty-five years. The increase in infectious syphilis has prompted the Division of STD Prevention to develop new materials with a different approach to STD prevention, as well as to bolster existing initiatives.

"STD Prevention for You and Your Partner" is a new brochure developed for people recently diagnosed with infectious syphilis. The brochure emphasizes that MDPH partner services are private and confidential: all partners are contacted without using any identifying information about the index case. The brochure also describes how named partners are encouraged to seek medical care and be screened and treated for syphilis promptly. The brochure will be available at all state-funded STD clinics and at private provider offices.

The website www.gettestedboston.org has been in existence for five years. The target audience of the website is MSM. In collaboration with Fenway Community Health, a promotional campaign for "Get Tested Boston and Beyond" will be launched in September, 2008. The goal of "Get Tested Boston and Beyond" is to increase the number of MSM getting screened for STDs. People visiting the site can find a testing location by reading a user-friendly map. Recently there were several new testing sites added. A new feature, "The Top Questions," has been added to the home page. These questions were culled from commonly asked questions from MSM patients.

David Goudreau is MDPH's Syphilis Elimination Coordinator. If you have any questions or would like to share ideas on prevention initiatives please contact him at (617) 983-6835 or david.goudreau@state.ma.us.

Sex and the Internet: Challenges and Opportunities for STD Control

You don't have to be part of the MySpace Generation to know that the Internet has become a popular tool for networking and meeting new people. As the information superhighway connects people across states and regions for news, commerce, and education, it is only logical that the dating pool expands geographically too. Popular networking sites such as MySpace and Facebook report over 115 million users each worldwide.

With growth in Internet traffic, opportunities for conducting sexually transmitted disease (STD) interventions online are expanding as well. In addition to general STD health promotion work such as banner ads and links to testing sites and STD information, the Division of STD Prevention has found the Internet to be an increasingly useful tool for their Partner Notification Program. While staff once focused the majority of effort exclusively on soliciting physical descriptions and partner hangouts, patient interviews have progressed to include online screen names and websites. The Massachusetts Department of Public Health (MDPH) has created several Partner Notification profiles for popular websites, and online partner notification efforts have increased 500% since 2007.

Expanding partner services to incorporate the Internet has many advantages. The Internet is a great way to contact a younger, technically savvy, and more mobile population; home phone numbers and addresses change frequently in this demographic, yet online profiles and email addresses often remain constant. Because of the anonymity inherent in contacting an individual online, the onus is on the partner to call back MDPH staff for more information or to receive assistance in seeking care. The individuals that receive on-line messages from MDPH are often grateful for the news and express their appreciation that such a program exists.

MDPH staff are still hitting the pavement daily to assist in bringing exposed individuals in for testing and treatment through traditional means. But as technology progresses, the Division of STD Prevention's multi-faceted approach to partner notification will continue to evolve as well. For more information on partner notification, contact Hillary Johnson, Director of Field Services, at (617) 983-6951 or hillary.johnson@state.ma.us.

Culturally and Linguistically Appropriate Services (CLAS) Initiative

In 2001, the US Department of Health and Human Services Office of Minority Health released national standards on the provision of culturally competent services. The fourteen Culturally and Linguistically Appropriate Services (CLAS) Standards are intended to:

- Contribute to the elimination of racial and ethnic health disparities;
- Make services more responsive to the individual needs of consumers; and
- Be inclusive of all cultures, but designed to address the needs of racial, ethnic, and linguistic population groups.

The fourteen CLAS standards for health care organizations (HCOs) are organized in three sections: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). The Massachusetts Department of Public Health (MDPH) interprets "health care organizations" to include all agencies that provide public health services.

MDPH & CLAS

The MDPH Office of Health Equity was awarded a state partnership grant from the US Office of Minority Health to create the MDPH CLAS Initiative. The Office of Health Equity-led Initiative draws from the expertise of over forty MDPH staff across six bureaus, including the Bureau of Communicable Disease Control.

The goals of the MDPH CLAS Initiative are:

- To enhance coordination among MDPH and its contracted vendors to benefit minority health and contribute to the elimination of health disparities.
- To establish a common understanding of health disparities;
- To establish procedures for the development and implementation of a uniform CLAS component for MDPH Request for Responses (RFRs);
- To establish evaluation criteria to evaluate CLAS through the state contracting system as one factor related to contractor performance.

Utilizing a committee infrastructure to attain its goals, the MDPH CLAS Initiative works to integrate the CLAS Standards into the infrastructure of MDPH. The CLAS committees and their respective roles are:

- Coordinating: To provide leadership and coordination of CLAS initiative efforts and products
- Procurement: To integrate the CLAS Standards into the MDPH procurement process for services based contracts
- MDPH Internal Assessment: To conduct a survey to assess MDPH programs and workforce with regard to services that are targeted to racial, ethnic and linguistic minority populations
- Guidance Manual: To develop a guidance manual for MDPH programs and contracted agencies with specific tools for CLAS Standard implementation
- Contract Management Guide: To develop a tool for MDPH contract managers to assist in their work with contracted vendors implementing CLAS Standards
- Communications: To develop and implement a communications plan for the CLAS Initiative
- Community/Provider Outreach: To identify and implement ways to incorporate the community voice into the CLAS Initiative
- Training: To develop and implement a CLAS Training Series to inform MDPH staff and contracted vendors of promising practices in health disparities elimination
- Evaluation: To guide the process evaluation of the CLAS Initiative

Membership in CLAS Committees is open to all, including agencies working within communities most affected by health disparities. While most committee meetings are held at MDPH in Boston, teleconferencing is always available. Individuals interested in learning more about the MDPH CLAS Initiative, or receiving the monthly e-mail update, are invited to contact CLAS@state.ma.us or 617-994-9806.

Article written by Christine Haley Medina, MDPH Office of Health Equity

Standard 1	Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
Standard 2	Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
Standard 3	Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
Standard 4	Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter

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National Call to Action on Tuberculosis Isolation

At the Northeast TB Controllers meeting on September 19, 2007, the assembly voted to request that the National TB Controllers Association (NTCA) call upon the Division of TB Elimination at CDC to assemble a working group of experts and stakeholders to establish the minimum legal standards and best practices for the use of enforcement powers leading up to and including the isolation of infectious TB patients. The issues to be addressed included providing appropriate housing and treatment plans for patients who are nonadherent to infection control measures and therefore pose a potential health threat to others. The National Call to Action was submitted to the NTCA and the CDC during the fall of 2007.

The practice of voluntary and involuntary isolation to prevent the transmission of tuberculosis (TB) varies considerably from locality to locality and from state to state. Recent cases have dramatically revealed the unevenness of these practices and the controversies surrounding the laws and interpretation of laws intended to protect the public from infectious TB. These cases suggest that TB programs and the public would benefit from having specific standards and best practices defined to address the complex issues raised in the emerging national discussion on public health powers for individual isolation of contagious persons as well as in an emergency response to a pandemic of influenza.

The National Call to Action suggests that the following issues need to be addressed:

Assuring equity of case management
Two cases illustrate the vast differences in applying public health law. In the case of Andrew Speaker of Georgia, a well-to-do professional, all possible measures to convince him to accept voluntarily the medical advice of his doctors were brought to bear including the involvement of family members and providing transportation to the nation's premier hospital for treating drug-resistant TB. In the case of Robert Daniels of Arizona, an indigent Phoenix man, he was incarcerated in the local jail, had 24 hour surveillance with the lights on, had his personal property (such as a radio) taken away, was denied showers, was not given permission to talk with friends or the press; essentially in lock down for 12 months. Although both men were nonadherent to infection control measures, one person intentionally eluded travel restrictions while the other apparently had an unclear understanding of the risk in which he was placing other persons by not wearing a mask. Why were the isolation and treatment measures taken for these patients, both thought to have extensively drug resistant TB (XDR-TB), so different?

Defining infectiousness
The Speaker case calls into question the grounds upon which a person with tuberculosis is determined to be a threat to the community. Although TB isolation laws often refer to "infectious TB", some TB programs have applied public health laws to patients with sputum smear negative TB who are nonadherent during treatment. The decision to isolate Speaker was based less on his degree of infectiousness and more on the strain of TB. Since second-line drug susceptibility testing is less standardized, should XDR-TB be verified by a reference laboratory? What is the risk to other individuals? Should all patients with XDR-TB be isolated until they are culture negative?

Protecting the public health – enforcement concerns
The police powers of public health officials are derived from common law and are defined in statutes that give such power to local and/or state officials. Federal officials (CDC) have authority to prevent or interrupt interstate transmission of TB and to take measures regarding persons who travel internationally, as well as measures for immigrants and refugees. Federal law, however, does not apply in other countries (e.g., CDC cannot require isolation of a U.S. citizen who is living abroad). What measures can be taken in the face of private providers who are unwilling to accept or demand adherence to standard infection control measures, such as directly observed therapy or fulfilling reporting, discharge planning, and treatment plan requirements?

Ensuring individual rights and due process
Isolation of contagious individuals must be done witht guarantees of equal protection under the law and patients' rights, including the right to adequate written notice detailing the grounds for isolation, the right to a hearing before an impartial decision maker, the right to appeal, and the right to the least restrictive confinement. The TB health order must define the person's situation or behavior that justifies the order, including the measures attempted and their lack of success.

Committing patients across state lines – identifying state and regional models
In the Northeast, a regional TB unit, for isolation and treatment of TB patients, is the Tuberculosis Treatment Unit (TTU) at the Lemuel Shattuck Hospital in Boston. The TTU is a closed unit that has a multidisciplinary team, with interpreters and culturally competent staff. The TTU is able to address complex treatment problems in addition to behavioral and adherence issues. The facility has been used by several states on occasions when those states have not had an adequate facility to isolate a patient. One limitation of this model is that patients from other states may have to be voluntarily committed to the Shattuck, which limits use in circumstances of involuntary isolation.

Financial considerations: who pays?
In this period of resource-restricted TB prevention and control, prolonged isolation in a hospital or other restricted environment may be cost prohibitive. The costs of home isolation are usually borne by the patient in the form of lost income. Patients with insurance may receive coverage of hospital charges only during

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You Be the Epi

Confirming Cases of Legionellosis

In late August 2007, the Massachusetts Department of Public Health (MDPH) Office of Integrated Surveillance and Informatics Services (ISIS) received an electronic report from a reference laboratory on a Massachusetts resident of a single legionella IgG antibody titre of 1:128. The reference laboratory flags this value as a "high" or "positive result." This was the only information received by MDPH.

What causes legionellosis?

The bacterium *Legionella pneumophila* and other Legionella species can cause a sometimes serious and potentially fatal form of pneumonia called legionellosis. The disease got the name, Legionnaire's disease, in July 1976 when many people who went to Philadelphia for an American Legion convention became ill with symptoms of pneumonia with high fever. Since then, a number of outbreaks of legionellosis have been linked to poorly maintained aerosol-generating water systems, including air cooling towers, misters, whirlpools and spas. These environments provide the three conditions necessary for transmission of legionellosis: heat, stasis and aerosolization of the organism; and are therefore common sources for outbreaks of this disease.

Does this person really have legionellosis?

Legionellosis is associated with two clinically and epidemiologically distinct illnesses: Legionnaires' disease, which is characterized by fever, myalgia, cough, and clinical or radiographic evidence of pneumonia; and Pontiac fever, a milder febrile illness without pneumonia. For public health purposes, cases are classified as suspect or confirmed based on clinical findings and laboratory results.

A clinically compatible case of legionellosis that meets at least one of the following laboratory criteria is considered "suspect."

- A fourfold or greater rise in antibody titer to specific species or serogroups of Legionella other than L. pneumophila serogroup 1.
- A fourfold or greater rise in antibody titer to multiple species of Legionella using pooled antigen.
- The detection of specific Legionella antigen or detection of the organism in respiratory secretions, lung tissue, or pleural fluid by direct fluorescent antibody (DFA) staining, immunohistochemstry (IHC), or other similar method.
- The detection of Legionella species by a nucleic acid validated assay.

A clinically compatible case of legionellosis that meets at least one of the following laboratory criteria is considered "confirmed."

- Isolation of any Legionella organism from respiratory secretions, lung tissue, pleural fluid, or other normally sterile fluid by culture.
- The detection of Legionella pneumophila serogroup 1 antigen in urine.
- A fourfold or greater rise in specific serum antibody titer to Legionella pneumophila serogroup 1.

A single antibody titer is not diagnostic even in the presence of clinical signs and symptoms suggestive of legionellosis, including a positive chest x-ray for pneumonia. Additional testing, such as a second antibody test taken four weeks later (paired acute and convalescent serology) with a four-fold rise in titer would be needed to categorize a case as either suspect or confirmed for public health purposes.

What is the best test to confirm legionellosis disease?

The following table highlights the sensitivity and specificity of the various diagnostic tests available for legionellosis. It is recommended that in addition to serologic or urinary antigen assays, cultures for the bacterium also be performed. These respiratory cultures may be compared to environmental isolates to help verify source of environmentally-associated outbreaks.

Test	Sensitivity (%)	Specificity (%)
Culture	80	100
Urine Antigen	70	100
Paired Serology	70 – 80	≥90
Direct Fluorescent Antibody Stain	25 – 75	95

What is the appropriate treatment for legionellosis?

The appropriate treatment for Legionnaires' disease is antibiotic therapy. Please see the most recent guidelines from the Infectious Disease Society of America (IDSA) on treating community-acquired pneumonia (IDSA/ATS Guidelines for CAP in Adults. *CID* 2007:44 (Suppl 2). Mandell et al.). Pontiac fever is typically a self-limited disease and usually does not require antibiotic therapy.

Are certain people at an increased risk for developing legionellosis?

People most at risk of getting sick from the infection are older people (usually 65 years of age or older), as well as people who are smokers, or those who have a chronic lung disease (like emphysema). People who are immunocompromised are also at an increased risk for developing legionellosis.

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HIV/AIDS Surveillance

A New HIV Incidence Estimate for the United States - 2006

Estimates from the Centers for Disease Control and Prevention (CDC) derived from a new HIV incidence surveillance system reveal more new infections than previously estimated.

Using a new technology called serological testing algorithm for recent HIV seroconversion (STARHS) that distinguishes recent from longstanding HIV infections, CDC estimates that 56,300 new HIV infections occurred in the United States in 2006. Prior to the availability of STARHS, CDC estimated that approximately 40,000 new HIV infections occurred each year since the 1990s. The new estimate underscores the need to reach all populations at risk for HIV infection with effective prevention programs and serves as a reminder of the need to do more to prevent the further spread of HIV. For more information on the 2006 HIV incidence estimates go to: http://www.cdc.gov/hiv/topics/surveillance/incidence.htm. Also, the study reporting this incidence estimates is published in the Journal of the American Medical Association, Vol. 300, No. 5, August 6, 2008.

In the coming months, CDC will be providing computer programs and protocols to individual state health departments to enable them to generate state-specific HIV incidence estimates. The MDPH HIV/AIDS Surveillance Program will be generating an estimate based on this estimate.

www.STD411.org

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Action Committee (phone) 617.450.1201 (fax) 617.437.1186 or via email: asmith@aac.org to order materials, request a visit, or for more information about STD411.org.

HIV/AIDS Medical Abstraction Study Seeks to Validate Surveillance Data

In 2007, the HIV/AIDS Surveillance Program began a study of the validity of data reported to the surveillance system. For the purpose of the study, validity is defined as the degree to which reported information is accurate. For example, does the reported date of a patient's first positive HIV test accurately reflect the date recorded in the patient's medical record? In order to assess HIV/AIDS data validity, a medical chart abstraction study was undertaken at the recommendations of the Centers for Disease Control (CDC).

The objectives of this study are to:

- Assess agreement between information recorded in the surveillance system and information in source records;
- Learn whether specific data elements have higher error rates than others;
- Determine if data validity varies by facility; and
- Define limitations of surveillance data.

Records for inclusion in the study were randomly selected from among all adult patients diagnosed and reported to the HIV/AIDS Surveillance Program in 2007. Surveillance program staff then visited the facilities to review the medical charts and abstract a portion of the information originally reported to the program. The results were compared to the original report forms, and any errors or discrepancies were recorded. Major discrepancies between data sources will be resolved through further follow-up with the reporting facility.

The results of the comparison for each variable are being compiled, and agreement and error rates for each data element will be calculated. Possible outcomes of this study include the modification of reporting instructions and/or provider training. This study is currently in the analysis phase, and results are forthcoming.

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Current and past issues of CD Update are available online at:
http://www.mass.gov/dph/cdc/update/comnews.htm

Contact Jacqueline Dooley at jacqueline.dooley@state.ma.us or (617) 983-6559 to have PDF versions emailed to you.

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Culturally and Linguistically Appropriate Services (CLAS) Initiative

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Standard 4 cont. services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5 Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6 Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7 Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8 Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9 Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10 Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11 Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12 Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13 Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14 **Health** care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

National Call to Action on Tuberculosis Isolation

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their immediate infectious period. Is the cost of TB control inherently the responsibility of a state or locality?

The National Call to Action summarizes by saying: "The field of TB isolation is a complex balance of protecting the public's right to be free of exposure to dangerous pathogens and the individual's right to have their freedom and person protected from unwarranted incursions and restrictions by the state. The two recent cases of presumed XDR-TB have reinvigorated the debate regarding collective welfare and civil liberties and the need for a national action plan."

You Be the Epi

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Is any additional follow-up necessary?

Both suspect and confirmed cases of legionellosis should be investigated by local health departments using the MDPH Legionellosis Confidential Case Report Form, paying particular attention to the questions regarding travel. Details regarding exposures for cases that have traveled in the 14 days prior to symptom onset should be forwarded to MDPH as soon as possible. This information will then be reported to the Centers for Disease Control and Prevention to facilitate more timely recognition of outbreaks.

For more information: http://www.cdc.gov/legionella/index.htm or http://www.who.int/mediacentre/factsheets/fs285/en/print.html.